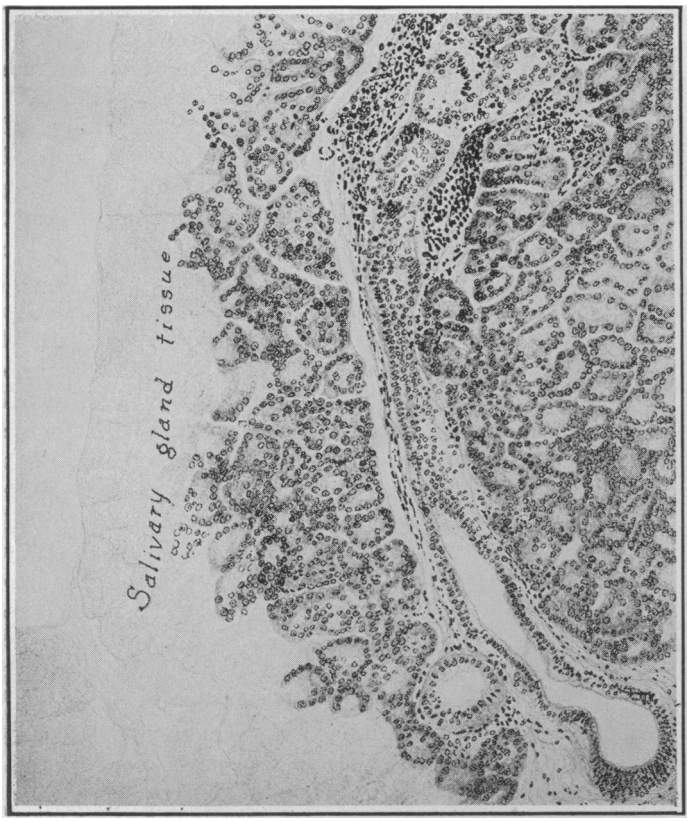

Fig. 3.—Microscopic section of salivary gland tissue removed from tonsil fossa

ing chiefly of mucous alveoli. There was considerable round-cell infiltration around the secretory ducts.

This case is reported on account of its interest in diagnosis in the operation of tonsillectomy and on account of its interest as a morphologic variation of the tonsil fossa.

Woodland Clinic.

REFERENCE

1. Neuman, H.: Aberrant Salivary Gland in Tonsil, Wien. Med. Wochnschr., 78, 650, May 12, 1928.

HORSESHOE KIDNEY*

REPORT OF CASE

By A. J. SCHOLL, M. D.
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ANOMALIES in the urinary tract of themselves are of no clinical significance. It is only when some pathologic complication occurs that their recognition becomes of clinical as well as surgical importance.

Horseshoe kidney is one of the most common of the renal anomalies. It may function normally but, owing to the unusual location of the renal mass and the deficient pelvic drainage, it is relatively vulnerable to disease and trauma.

The following case of horseshoe kidney is one in which one-half of the renal mass was successfully removed for calculous pyonephrosis.

* Read before the Urology Section of the California Medical Association at the fifty-ninth annual session, Del Monte, April 28 to May 1, 1930.

REPORT OF CASE

A man, age thirty-seven, was referred on account of hematuria and abdominal tumor. Twelve years ago, several months after having a severe infection in the palm of his right hand, he developed a pain in the lumbar region, more pronounced on the left side but spreading over the entire lower back. This pain was fairly constant and dull, like a persistent "toothache." At times there was present another pain which was sharp, penetrating, and occurred in the left loin. This pain did not radiate, usually persisted one or two hours, and made him nauseated; the urine following one of the sharp attacks was usually dark-colored for several days. It has always been difficult for him to stand straight, a very erect position causing his pain to increase. He could stoop over and lift heavy objects readily without trouble. If he rode in a street car or an automobile it was necessary for him to put his closed fist between his back and the seat. Three months ago he stepped over a car step quickly. following which he had more pain, passed dark urine frequently and began to lose weight; he lost ten pounds in three months. Shortly after this he felt a mass in his lower left abdomen. Palpation of this mass by his doctor caused him to have a marked hematuria for twenty-four hours. There has been no dysuria or marked frequency, but for ten years he urinated once or twice during the night.

Fifteen years ago his appendix was removed for general abdominal pain. There has been no other serious illness. His physical examination was not abnormal except for the abdominal findings. Palpation of the abdomen revealed a rounded, irregular tender mass in the lower left quadrant; it was firm, fixed, and about 15 by 25 centimeters in size. His urine was cloudy, had a specific gravity of 1020, and contained a trace of albumin, a large number of pus cells, and a few red blood cells. His blood contained 70 per cent hemoglobin, 5,000,000 red cells, and 12,000 leukocytes. His two-hour intravenous phthalein return was 65 per cent. X-rays of the urinary tract revealed a branching shadow 15 by 10 centimeters in size, opposite the third and fourth lumbar vertebrae. One segment of the stone extended downward and over the body of the fourth lumbar vertebra.

Cystoscopy revealed a moderately inflamed bladder with an increased amount of redness around the left ureteral orifice. Clear urine was spurting more frequently than normal from the right ureteral orifice. The urine was seen issuing from the left ureter during a period of five minutes; a few white flakes and a small amount of cloudy material could be forced out from the left orifice by making pressure over the mass in the abdomen. A large ureteral catheter was inserted in the right and a moderate-sized catheter inserted into the left ureter. Intravenously injected phthalein appeared from the right side in five minutes and 25 per cent of the dye was returned in fifteen minutes. Only a trace of dye appeared from the left side. The urine from the left kidney contained many pus cells, that from the right contained a few red blood cells (probably traumatic from the ureteral catheter). A right pyelogram showed that the lower pole of the kidney was opposite the fourth lumbar vertebra. There was an almost normal rotation of the right renal mass, the calices extending lateralward and anteriorly. The ureter had a high insertion on the anterior surface of the pelvis. There was no evidence of inflammatory dilatation of the pelvis or calices.

Operation.—Left posterolateral incision, extending from the angle of the last rib and the spine downward and forward to within an inch of the umbilicus. The muscles of the back were very thick and solid. The posterior spinal group of muscles and the quadratus lumborum were cut through completely, the peritoneum pushed forward, and the kidney separated out. There were several anomalous vessels that were isolated, clamped and tied. The kidney was about twenty centimeters long, soft, pyonephrotic, and moderately adherent to the surrounding structures; numerous segments of calculi could readily be felt through the thin shell of parenchyma. The pelvis and ureter were thickened, dilated and located on the anterior upper surface of the kidney. The ureter was clamped, cut, and both ends tied. The posterior surface of the kidney was smooth and extended down without irregularity to the large, thick isthmus, which was felt to be continuous with the opposite kidney. The vascular pedicle was triply clamped, cut and tied and the renal mass then pushed forward so as to expose the isthmus. The isthmus was five centimeters in diameter, composed completely of parenchymatous tissue and was not furrowed by any groove or sulcus which would indicate a division point between the two kidneys. A fragment of stone could be felt extending from the left kidney into the isthmus. The commissure was cut through, a V or wedge-shaped segment being removed so as to facilitate the closure of the remaining stump; the kidney was then removed. The opening in the isthmus was closed with a continuous catgut suture. A portion of the renal capsule and surrounding fat was sewed over the stump. Two Penrose drains were inserted down to the base of the wound and the incision closed.

The patient made a good operative recovery, was out of bed on the twelfth day, and his wound healed without any urinary drainage. Eighteen months later he had gained twenty-five pounds and was in excellent health.

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A VARICOSE VEIN INJECTING NEEDLE

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THE accurate insertion of a hypodermic needle into thin-walled, tortuous varices, without penetrating both walls or having the needle become dislodged during the injection, is at times difficult. For such cases, a hooked hypodermic needle is proposed which will hang in the lumen of the vein without becoming dislodged while the patient is being placed in the desired position to continue the injection. An ordinary one-inch 26-gauge, rustless hypodermic needle with a full-sized well-fitting wire stylette, is carefully annealed near its base and bent over the jaws of round-pointed pliers to an angle of 45 degrees or less, so that it will not become kinked. The wire can be removed readily if the annealing and bending have been done properly. The point of the needle is sharpened to a short bevel facing either side of the plane of angulation for right or left-handed operators, or toward the hub of the needle, as may be desired.

The best way to distend varicose veins is to have the patient stand. The hooked needle is held at a right angle in the end of a light mosquito hemostat which will not crush it and is inserted into the vein, point downward, according to the skill and *modus operandi* of the surgeon. The instant the point of the needle penetrates the wall of the vein can often be felt and is verified immediately by the appearance of blood at its open end. A gauze sponge should be at hand to catch the few drops of blood which escape. The hemostat is released gently, leaving the needle hanging in the vein while the patient is being placed in the horizontal position if desired.

Pressure of a finger on the angle holds the needle in place while the syringe is carefully adjusted. After the position of the needle has been verified again, this time by drawing blood back into the syringe, the injection is continued in the usual manner.

The advantages of the hooked hypodermic needle for injecting difficult varicose veins are:

1. It can be handled more delicately in a light hemostat, permitting greater accuracy in venepuncture.

2. There is less likelihood of penetrating both walls of the vein and resultant leakage into the tissues.

3. It will hang by itself without becoming dislodged while the patient's position is being changed for the injection.

4. The inconvenience of having to follow the moving of the patient with the syringe attached to the needle and losing its position are eliminated.

5. Special tables or chairs for handling the patient are not needed.

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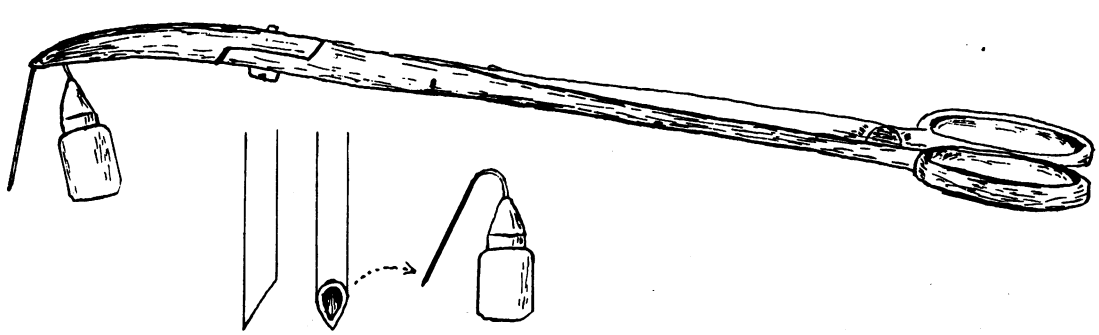

A varicose vein injecting needle